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Welcome to the Spring 2010 edition of Commonwealth Orthopaedics. This issue focuses on several cutting-edge orthopaedic procedures that our physicians are performing that may be of interest to you and your patients.

Continuing with our tradition of sharing actual patient experiences, we are pleased to include articles highlighting cases of total ankle replacement and muscle sparing total knee replacement. Also, an old orthopaedic approach is made new again with the direct anterior hip replacement, making even quicker recovery and less pain possible. We also focus on a modern multimodal pain management for surgery and roll out a promising new technique for chronic tendon or joint problems – Platelet-Rich Plasma (PRP).

In addition to the various orthopaedic problems our physicians treat everyday, we are proud of their volunteer efforts in their communities as well. Just this year, Commonwealth Orthopaedics sponsored two educational workshops: Collaborating Care Between Sports Medicine Physicians and Athletic Trainers, and Keeping Your Soccer Players Healthy – you can read more about these community events on page 12 or on our website at www.c-o-r.com.

I hope you enjoy reading the articles enclosed. Now in our 16th year, we as stand as committed as ever to provide excellent orthopaedic care and service to our community.

Sincerely,

Mark C. Hartley, MD
President
Commonwealth Orthopaedics
Muscle-Sparing Total Knee Replacement

For more than five years, Jerri ignored the increasing pain in her left knee. The 64-year-old Alexandria psychotherapist knew she'd ultimately need a knee replacement, but she wasn't ready to give up her active, athletic lifestyle. She spent busy days seeing patients, performing community work with the homeless, and keeping up with her six grandchildren. Running, swimming, biking, and boating were often on her schedule.

But when the pain finally forced her to limit her activities, she knew she had to take the plunge. “The most important thing for me was finding a physician and a team that were eager to partner with the patient and focus on early mobilization to ensure the best possible outcome,” she says.

A three-month search led her to Commonwealth Orthopaedics and surgeon Mark Hartley, MD, who performed a state-of-the-art, minimally invasive muscle-sparing total knee replacement in December 2008.

This innovative technique (also called quad-sparing knee replacement) combines the latest minimally invasive methods with a surgical approach that leaves key muscles and tendons intact. Instead of cutting the quadriceps tendon, surgeons make a 3-5 inch incision on the knee and split or dissect under a single quadriceps muscle. Because the incision is very small and no major tendons or muscles are cut, recovery is faster and less painful.

“Muscle-sparing knee replacement offers patients numerous advantages over traditional knee replacement,” says Dr. Hartley. “Patients have more rapid return of knee function and regain muscle strength and control more quickly. The technique leaves the quad extensor mechanism intact, so patients are able to lift and bend their leg within the first hours after surgery. Later, when we take them to their hospital room on a stretcher, they walk from the door to their bed, which is quite remarkable.”
Jerri opened her eyes after surgery to see a list of muscle-strengthening exercises on the ceiling and began lifting and flexing her leg right away. A few hours later, she walked from her hospital room out into the hallway and back to her bed. “My goal was to become very active, very quickly and Dr. Hartley and his team gave me plenty of opportunities to realize my capacity and achieve my objectives. They told me there was no reason I couldn’t walk right away and I did,” she says.

Her pain was short-lived and very manageable, like “dental surgery.” And her recovery was equally successful. After two nights in the hospital, she returned home and began physical therapy. Within three weeks, she was back at work part-time and climbing the stairs to her office. Soon, she was walking two miles a day. A month later, she helped her husband set up hypothermia shelters for the homeless, a task that involved much physical labor. “There were absolutely no limitations,” she recalls.

With the advent of smaller instruments, computer-assisted navigation, improved retractors and implants, and better pain protocols, muscle-sparing knee replacement has taken off in recent years, and Commonwealth is on the cutting-edge of performing this technique. “It’s revolutionized early ambulation and function and minimized pain. When you combine it with a small incision and multimodal medication approach, patients such as Jerri really get up and go very quickly,” Dr. Hartley says.

Knee problems are the most common reason patients visit orthopaedic surgeons and osteoarthritis, fractures, and wear and tear injuries are among the most common reasons for knee replacement. “Most everyone is a candidate for this procedure unless they have a lot of scar tissue from previous surgeries or are severely overweight. But for 85-90% of patients, this is the knee replacement approach of choice,” says David Romness, MD, who performs muscle-sparing knee and other total joint replacements at Commonwealth.

More than a year out from surgery, Jerri continues to excel. She calls her Commonwealth experience “quite amazing” and credits superior patient education from a caring and attentive team as key in helping her reach her goals. “From the beginning, their focus is on wellness and restoring a high level of function,” she says. “They don’t set any barriers or say you can’t do things well afterwards. They ask you what you want to do and work with you to make a plan to get it done. It’s a true partnership.”

**Direct Anterior Total Hip Replacement**

Celindah was preparing for a knee replacement last fall when she received some startling news. The pain in her right groin, which she thought was an injury, turned out to be osteoarthritis. Before she could have her knee replaced, she would need a total hip replacement.

“I couldn’t believe it,” recalls the 65-year-old from Aldie, Virginia, who loves to garden and spend time with her young granddaughter. “I immediately called a friend who’d had a double hip replacement and asked her what I should do.”

Fortunately for Celindah, her friend had the answer: anterior total hip replacement. In this procedure, the surgeon reaches the hip joint from the front instead of the back or side. Muscles are split, rather than removed and reattached, which leaves those most important for hip function—the gluteus muscles that attach to the pelvis and femur—undisturbed.

“The anterior approach is far less traumatic for patients,” says Commonwealth Orthopaedics surgeon Mark Madden, MD, who performed Celindah’s hip replacement last November. “We use a very small incision, so pain and bleeding are minimal. We don’t cut any muscles, so patients are stronger afterward and recover function much more quickly. And because we go in through the front of the hip, leg length is more accurately controlled and dislocation risk is reduced.”

Anterior hip replacement is not new. Surgeons used to perform it all the time. But it fell out of favor decades ago due to sub-standard equipment and materials. Now, thanks to advances in minimally invasive surgical techniques, more specialized instrumentation, and state-of-the-art prosthetics, it’s making a comeback. Commonwealth surgeons currently perform about 25% of hip replacements this way and the number of anterior hip replacements is on the rise.
“The procedure is more technically demanding than the traditional lateral or posterior version, and there are only a handful of orthopaedic surgeons in the Washington area who perform it routinely,” Dr. Madden says. “At Commonwealth, we believe the advantages to patients outweigh the difficulties.”

One of those advantages is a shorter hospital stay, which has dropped from three or four nights with traditional hip replacement to one or two nights with minimally invasive techniques. Ultimately, Commonwealth hopes to offer anterior hip replacement as an outpatient procedure.

Following her surgery, Celindah was taken by stretcher to her hospital room. At the door, she got up and walked to her bed. “I had no trouble putting one foot in front of the other,” she says. “The horrible pain I’d felt prior to surgery was completely gone.”

Back home, she was immediately grateful for all the little things she could now do pain-free: bend down to put on her socks, for example, or stand at the sink to wash the dishes. “Before I had this surgery, everyday living was so difficult, I was exhausted all the time. It wears you out.”

In February, just three months after her hip surgery, Celindah had a knee replacement. “To have enough stability and strength to support a total knee replacement within a few months of my hip replacement is incredible,” she says. “I’ve recommended Commonwealth to so many people and they all come back to thank me. These guys have figured it out. They know how to do it right.”

Celindah’s positive experience mirrors that of other patients in Commonwealth Orthopaedics’ comprehensive total joint replacement program. An overwhelming majority—99%—say that surgery alleviated their pain, while nearly 95% report “good to excellent” improvement in function and activity level. “The emphasis is on rapid recovery—getting patients back to their daily lives and activities as fast as possible with as little discomfort as possible,” Dr. Madden says. “We fix their wheel and put them back on the track.”

One super satisfied customer is Audrey, a 69-year-old grandmother from Herndon, who suffered from worsening osteoarthritis in her right hip. When the pain got so bad she felt she might fall down while walking, she consulted Mark McMahon, MD, at Commonwealth Orthopaedics. “He recommended a hip replacement, but I was initially skeptical,” she remembers. “I told him, ’I don’t have time for this, I’ve got things to do, places to go, and people to see.”

But the increasing pain finally convinced her to have surgery, and Dr. McMahon performed a direct anterior total hip replacement in January. During the procedure, he used intra-operative X-rays to be sure he was reproducing Audrey’s anatomy accurately. “We rely on these images, rather than the pre-op studies, to confirm we are getting restoration of the normal anatomy and make any necessary adjustments during the surgery,” he says. “As a result, leg length is much more precisely matched.”

Because anatomy is restored accurately and no muscles are disrupted, patients don’t need to take special precautions to prevent dislocation afterwards. They can put weight on the hip immediately for a faster, more pain-free recovery. In fact, the dislocation rate is only about 1/20th that of a standard hip replacement.

A couple of days after her surgery, Audrey was climbing up and down stairs in the hospital. When she returned home, she immediately did was a load of laundry. Soon she was cooking, cleaning, and resuming her role as caretaker to family and friends. “In just six weeks I was amazed how active I was able to be so quickly,” she says. “I didn’t want to be slowed down and I wasn’t!”

Audrey continues to progress. She enjoys volunteering at her church, especially preparing meals for those in need. Her pride and joy is her 4-year-old grandson, whom she calls her ‘motivator.’ She even took his picture to the hospital. “When caring for my grandson before my surgery, it was hard for me to tell him I couldn’t play outdoor activities with him because of my pain. Now I am looking forward to playing ball, Frisbee and taking walks with him and going fishing with my husband,” Audrey says. “I have tremendous regard for Dr. McMahon and the Commonwealth staff. They took wonderful care of me in every respect. I’m active; I feel great. Best of all, I don’t suffer with terrible pain anymore. Even my back pain has diminished, she says.”

**Multimodal Pain Management**

When contemplating surgery, pain is usually what patients fear most. Effective pain management is critical to a positive surgical experience. At Commonwealth, multimodal pain control is an integral component of the total joint replacement program. Injectable medications, customized to each patient’s specific surgical procedure, are used to target the four pain pathways in the nervous system: the brain, spinal cord, nerves, and surgery site.

“We approach pain from many different directions, before, during, and after surgery” Dr. Romness explains. “This includes pre-operative medications for proactive pain control, a regional...”
anesthetic such as an epidural, spinal, or nerve block to target pain pathways, local anesthetics injected directly into the surgical site to block pain stimulus, and NSAIDs to prevent inflammatory pain.”

Historically, strong IV narcotic medications were used to control surgical pain. But this single drug strategy often caused side effects such as mental confusion, uneven pain relief, nausea and vomiting, and delayed recovery. Multimodal pain management promotes a rapid recovery with minimal post-operative complications and discomfort.

“The multimodal method not only controls pain more effectively, it also lowers narcotic use so patients regain mobility faster with fewer difficulties,” Dr. Romness says. “Our total joint patients have excellent results, with significantly less post-operative pain and nausea. They recover more quickly, are more likely to go directly home after discharge, and are more satisfied with the outcome.”

Mark C. Hartley, MD, earned a BA from Princeton University and an MS from Georgetown University. He received a medical degree from Georgetown University School of Medicine and stayed on at Georgetown to complete both his surgical internship and orthopaedic residency. Dr. Hartley served as Chief of the Total Joint Replacement Service at Eisenhower Army Medical Center.
For most of his life, Matthew has battled juvenile rheumatoid arthritis, an autoimmune disease that attacks the joints and causes persistent pain, swelling, and stiffness. The 48-year-old systems analyst from Lucketts, VA, had suffered significant cartilage loss in all his joints, but the condition was most acute in his ankles. “My right ankle had deteriorated to the point where it was just bone-on-bone,” he says. “It was so painful, I’d have to walk on my toes when I got up in the morning. My wife told me I was moving like an 80-year-old man.”

Matthew knew he needed an ankle transplant, but he didn’t like the options available. As his pain intensified, he consulted Dean Bennett, MD, a joint replacement specialist at Commonwealth Orthopaedics, who recommended something new: the INBONE™ Total Ankle System. Created by engineering experts, this state-of-the-art implant replicates natural anatomy and features design elements already proven successful in hip and knee implants. It offers numerous advantages to patients including enhanced fixation, better fit, a less-invasive installation process, and minimal bone removal.

Matthew was convinced. “I’m an engineer so I know how these things work. It all looked good to me.” In January, he became the first patient in the metropolitan Washington area to have a total ankle replacement using the INBONE™ system.

“The primary advantage of the INBONE™ implant is the significant improvement in tibial fixation, which has historically been the greatest cause of failure in earlier models of ankle replacement,” explains Dr. Bennett, who performed Matthew’s procedure. “We construct the tibia on the operating table for a customized fit. Adjustable-length, stemmed tibia and talus components lead to better fixation. The implant technique leaves the fibula completely intact, requiring less bone removal and reducing the risk of postoperative bone failure and stress fractures.”

Matthew has recovered much more quickly than expected. He began flexing his ankle immediately after surgery and was walking on it at four weeks, instead of the usual six to eight. Now he’s busy building a carriage house on his property, and keeping up with his 9-year-old daughter, Maggie. “There’s no pain in the joint at all and I can walk longer distances without my ankle swelling. I feel healthy and fit. Best of all, I’m not walking like an old man anymore,” he says.

Although long-term follow-up of the INBONE™ system is still needed, short-term studies are encouraging and the frequency of use is increasing. “Ankle replacement is very desirable to alleviate pain and preserve mobility, but it’s a major procedure that should not be undertaken lightly,” Dr. Bennett says. “Good candidates are those who have significant arthritis of the ankle with adequate bone strength, and no gross deformity or history of infection. If joint replacement is not an alternative, ankle fusion remains a viable and valuable salvage procedure.”

Matthew feels fortunate to have found the solution to his debilitating ankle pain. “Commonwealth Orthopaedics is an excellent practice and Dr. Bennett is a great surgeon who is committed to helping his patients resolve their pain and restore their mobility and quality of life,” he says. “He knows I’m happiest when I’m busy and thanks to him I’m as busy as I can be. Life is an elixir and I want to enjoy all of it. Nothing is going to slow me down.”
Dean R. Bennett, MD, earned both a BA in Chemistry and a BS in Biology from the University of California in Irvine and received his medical degree from the University of Pittsburgh. He then completed both his general surgery and orthopaedic residency at Mercy Hospital and the University of Pittsburgh, respectively. Dr. Bennett completed an additional year-long orthopaedic surgery residency at the University of Glasgow in Scotland.

For full biographies visit www.c-o-r.com.

Matthew, the first patient in the metro Washington area to receive a total ankle replacement using the INBONE™ system, was back to building the carriage house on his property just several weeks after surgery.
For patients with chronic orthopaedic conditions, surgery was once the last best option. Now, advanced technologies and methodologies have yielded innovative treatments that help patients heal without going under the knife.

One of the most exciting new therapies is platelet-rich plasma (PRP), an emerging treatment that accelerates healing of tendon injuries using the body’s own platelets. This specialized process involves taking blood from the patient, spinning it down to harvest growth factor-rich platelets, then injecting them directly back into the injured tissue. PRP enhances the body’s natural healing capacity, but in a much more powerful form. It is most commonly used to treat tendon and muscle tears, acute and chronic muscle strain, ligament sprains, degenerative disorders, and joint pain.

“PRP is a mechanism to promote healing in injured tissues and get athletes back on the playing field more confidently and rapidly. It has been used in recreational and professional athletes for injuries such as tennis elbow, ligament sprains and hamstring strains,” explains Frank Pettrone, MD, who specializes in knee, shoulder, and sports medicine procedures at Commonwealth Orthopaedics. “We typically use it on patients with ligament tendon injuries or muscle pain that have failed to respond to more traditional treatments such as medication, steroid injections, or physical therapy.”

PRP is a simple, outpatient procedure that’s performed in the office. Patients usually notice results within several weeks, and healing may continue for months after the injection as the tissue repairs itself. It is not a painful injection and it can be repeated.
For patients with difficult-to-treat arthritis of the knee, Commonwealth offers a non-operative option: viscosupplementation. In this procedure, synthetic joint fluid is injected into the knee to cushion, protect, and lubricate the knee joint.

“This therapy is best for patients with mild to moderate arthritis that has not responded to basic treatments,” says Amanda Trucksess, MD, who specializes in physiatry at Commonwealth Orthopaedics. “Right now, it is most commonly used in knees, but trials are ongoing for uses in other joints.”

Injections are given several times over the course of two or three months, depending on an individual’s condition. Newer evidence suggests that, in addition to cushioning the knee joint, the injected fluid might actually help reduce inflammation by interfering with the chemical breakdown pathways in the cartilage cells.

“PRP and viscosupplementation are among the most sophisticated, innovative therapies to help people reclaim their lives,” Dr. Trucksess says. “Commonwealth is excited to offer our patients these cutting-edge treatment options.”

Frank A. Pettrone, MD, earned a BA from Brown University and a medical degree from Georgetown University. Dr. Pettrone completed both his internship and residency program at Georgetown University Medical Center. Then, before joining Commonwealth Orthopaedics, he served a tour in the United States Navy as an orthopaedic surgeon.

Dr. Amanda Trucksess, MD, graduated cum laude from the College of William and Mary with a major in kinesiology. She went on to earn her medical degree from the Virginia Commonwealth University School of Medicine at the Medical College of Virginia. Dr. Trucksess completed a four year residency in Physical Medicine and Rehabilitation at the University of Virginia.

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Commonwealth Orthopaedics recently hosted two educational workshops and a blood drive for the American Red Cross. The first workshop held in February, “Collaborating Care between Sports Medicine Physicians and Athletic Trainers” was attended by 60 athletic trainers, team physicians and orthopaedic surgeons. Topics presented were athletic pubalgia, hip dislocation, stress fractures, SI joint dysfunction, PRP injections, dental and eye injuries. “At Commonwealth Orthopaedics we are committed to working closely with certified athletic trainers at area high schools. We see them as critical partners in providing student athletes with information about injury prevention and rehabilitation,” said Mark Hartley, MD, President of Commonwealth Orthopaedics.

A second workshop, “Keeping Your Soccer Players Healthy,” was held for Southwestern Youth Association (SYA) soccer coaches. Over 20 coaches attended and received information from Commonwealth Orthopaedics physicians, Athletic Trainers and Family Practice physicians on prevention of ACL injuries; signs and symptoms of overuse injuries; recognizing and preventing concussions and proper nutrition and hydration for athletes.

Commonwealth Orthopaedics also partnered with the American Red Cross to host a blood drive in our Herndon Outpatient Surgery Center in January. Forty-four (44) people attended, twenty-five (25) of which were repeat donors and nineteen (19) were new donors. “It was very gratifying to be able to work with the Red Cross to help build up the blood supply after the holidays,” said Janet Ward, Director of Surgical Services for Commonwealth Orthopaedics. “Many of the donors were our employees and it’s a great way for our practice to give back to the community.”
As center back for the University of Pennsylvania varsity soccer team, Adrienne is used to tough athletic competition. But when she planted her right foot to kick a ball during practice last spring, she knew something was terribly wrong. “My leg gave out and I felt excruciating pain,” recalls the 19-year-old, who is about to complete her sophomore year at Penn.

Adrienne had torn her meniscus, the rubbery, C-shaped disc that cushions the knee and helps distribute body weight across the knee joint. Meniscus tears are extremely common in young women athletes, and often occur together with injuries to the anterior cruciate ligament (ACL).

A torn meniscus can result from any activity that forcefully twists or rotates the knee, so athletes in high demand stop-and-go pivot sports are most vulnerable. Contact athletes, such as football players, may have added risk. But meniscus tears happen to people of all ages and activity levels. In older adults, the cause is usually degenerative changes of the knee. Symptoms include pain and swelling along the joint line, catching or clicking, instability or giving way, and locking, in which the knee won’t straighten due to displaced meniscal tissue trapped between the joint.

Adrienne’s injury was severe: her meniscus had shifted into the joint, she was in pain, and she couldn’t straighten or bend her leg. Although treatment was available in Philadelphia, she opted to come home to Chevy Chase and have Thomas Klein, MD, care for her at Commonwealth Orthopaedics. Dr. Klein, who specializes in knee, hip, and shoulder procedures, had repaired Adrienne’s ACL two years earlier. “He understands the pressures and challenges of being a Division I college athlete,” Adrienne says. “We have a great relationship and I knew he could help me get back to soccer healthy and strong.”

After discussing treatment options, they agreed on a repair technique that combined arthroscopy with open surgery. “At Commonwealth, we tailor treatment to the demands of each individual patient,” Dr. Klein explains. “Those with smaller tears may have a completely arthroscopic procedure...
with tiny incisions—the very latest technique. For others like Adrienne, who want to return to high-level athletics as soon as possible, we use an older method that blends arthroscopy with open surgery. It’s a little more complex, but it has a 95% success rate.”

Because the meniscus aids in load transmission, stability, shock absorption, position, and movement, repair is the treatment of choice. But most tears are not repairable. In fact, the vast majority of Commonwealth patients—between 85 and 90 percent—have their meniscus removed rather than repaired.

“Treatment options depend on the type of tear, location, chronicity, and injury to other structures such as the ACL,” says Robert Dombrowski, MD, who specializes in sports medicine, total joint replacement, and knee and shoulder surgery. “At Commonwealth, treatment ranges from conservative management, such as observation and activity modification, to operative management—either arthroscopic menisectomy to remove the damaged tissue, or open or arthroscopic repair.”

Size and setting are critical factors in deciding whether to repair or remove a torn meniscus. “Repair is an option only when it’s an outer rim injury where there is still blood flow to help with healing,” says Dr. Klein. “When it’s an inner edge tear, and there’s no blood flow, it’s like a hangnail. It will flap and flap and never heal, so we must remove it.”

Arthroscopic repair techniques continue to evolve. One of the most promising is the Maxfire MarXmen™ meniscal repair system, which is the first of its kind to eliminate polymer and surface knots and protect the surrounding structures in the joint. Developed by Commonwealth Orthopaedics surgeon Keith Lawhorn, MD, in conjunction with Biomet Sports Medicine, the system mimics the gold standard inside-out suture repair constructs. “I’ve been using this for two years with great results,” Dr. Lawhorn says. “Eliminating polymers and surface knots enhances the safety of the repair technique because there are no polymer- and knot-related complications to the joint.”

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Currently, there are several studies underway exploring the use of platelet-rich plasma (PRP) to augment the healing of meniscal repairs. In PRP therapy, a patient’s own blood components are injected directly into damaged tissue, enhancing the body’s natural healing process and accelerating recovery. (see related article on page 10) It is unclear if PRP will prove beneficial to healing of meniscal tear repairs as data from the studies involving meniscus injuries are not yet available.

Meniscal transplantation remains an option for younger patients with preserved joint surfaces but with pain due to a meniscal deficient compartment. Patients must have a stable knee with no ligamentous deficiency (ie: ACL tear) and normal alignment. Careful patient selection has resulted in improved short-term functional outcomes in these patients with significant loss of meniscal function. Long term results with regards to the prevention of knee osteoarthritis in these carefully selected patients have not yet to be proven and therefore must be considered a salvage intervention. Preservation of meniscal function of the patient’s own meniscal tissue is always preferable if possible. Dr. Lawhorn will chair an instructional course on this trend at the 8th Biennial International Society of Arthroscopy Knee Surgery and Sports Medicine Congress in Brazil next year.

Following her meniscus repair last April, Adrienne spent the summer in physical therapy rebuilding her strength and stability. She progressed from walking on flat surfaces to biking, and then began running at the end of July. By mid-August she was back at school, taking part in technical drills with the Penn soccer team. One month later she was cleared to start contact play. On the final weekend of September, just five months after her surgery, she took the field in the Penn-Harvard game, and she’s been playing ever since. "I completely trusted Dr. Klein’s opinion and ability,” she says. “My knee healed beautifully and I was able to get back on the soccer field safely. He had my best interests at heart.”

Adrienne credits her orthopaedic surgeon for her quick return to playing Division I soccer, “I completely trusted Dr. Klein’s opinion and ability.”

Robert M. Dombrowski, MD, received a BA in Biology from Washington and Jefferson College before going on to Case Western Reserve University in Cleveland, Ohio, where he earned his medical degree. He then completed his surgical internship and residency training in orthopaedic surgery at Georgetown University in Washington, DC.

Thomas J. Klein, MD, earned a BA in biology from Washington and Jefferson College before going on to graduate from medical school at Georgetown University School of Medicine. He completed his surgical internship in Danville, Pennsylvania, and did an orthopaedic surgery residency at Georgetown University Medical Center.

Keith W. Lawhorn, MD, graduated with a BA in Chemistry from the University of Virginia and continued his education at the University of Virginia School of Medicine, where he earned his medical degree. He completed a general surgery internship and orthopaedic residency at the Medical College of Virginia. Dr. Lawhorn served on active duty in the U.S. Air Force for eight years, reaching the rank of Lt. Colonel.

For full biographies and a complete directory of the physicians at Commonwealth Orthopaedics who perform these and other procedures visit our website at www.c-o-r.com.
A VICTORY LAP
AROUND THE FAST TRACK
Back and neck pain are extremely common, affecting more than 90% of people at some point in their lives. Although most episodes resolve on their own, it’s important that patients see a physician for proper evaluation, diagnosis, and treatment. When Patson first felt neck pain, he dismissed it as a minor nuisance. But the pain worsened over time and the 41-year-old Annandale resident sought treatment at a number of local hospital emergency rooms. “Each time, they told me it was nothing serious and sent me home,” he recalls. After a long drive from North Carolina, the pain became so acute he called 911 to take him to the emergency room once again. There, an MRI revealed the worst: a huge herniated disc was crushing his spinal cord.

The radiologist immediately called Commonwealth Orthopaedics surgeon Thomas Mazahery, MD, who rushed to the emergency room. “When I got there, Patson was almost completely paralyzed,” Dr Mazahery recalls. “He had no sensation from the waist down and no motion in his legs—a progressive neurological deficit. There are very few emergencies in spine surgery. This was one of them.”

A herniated disc occurs when one of the small, spongy discs that cushion the vertebrae bulges or breaks open. Also known as a slipped or ruptured disc, this condition can affect any part of the spine, but is most common in the lower back. “Think of a jelly doughnut where the jelly has ruptured,” explains Ronald Childs, MD, who specializes in spine surgery at Commonwealth Orthopaedics. “When a herniated disc bulges out from between the vertebrae, the spinal nerves and spinal cord become pinched, causing pain in the back or neck, or radiating down an arm or leg. Patients also may experience numbness, tingling, or pins and needles.”

Herniated discs are very common. They are usually the result of injuries, wear and tear, or degeneration over time. In many cases, the problem will resolve on its own. But if the pain persists or becomes worse, patients should see their physician. “Prompt evaluation, diagnosis, and treatment are essential, especially if symptoms include progressive weakness, numbness, or tingling, or if balance or coordination problems develop,” says Tushar Patel, MD, an orthopaedic spine specialist at Commonwealth Orthopaedics. “It’s important that the evaluation include a thorough examination of the cervical spine as well as the lumbar spine. People don’t usually associate neck pain with herniated discs, so they might not make the connection.”

Treatment ranges from conservative methods such as anti-inflammatory medications, epidural injections, and physical therapy, to surgery. “Surgery is usually a last resort and performed if the disc is touching the spinal cord and causing compression or a neurological deficit,” says Steven Hughes, MD, who specializes in spine procedures at Commonwealth Orthopaedics. “Many of my patients come in afraid they will need surgery, but I reassure them that for most people—between 75 and 80%—conservative treatments do the trick.”
Patson’s situation, in which the herniated disc had grown so large it crushed his spinal cord, was extremely rare. And his prognosis was poor. As he prepped for emergency surgery, Dr. Mazahery delivered the difficult news. “I had to look him in the eye and tell him he might never walk again,” he says. During the procedure, Dr. Mazahery performed a corpectomy to decompress Patson’s spine, removed two discs, and reconstructed his cervical spine with a bone graft. Time was of the essence because his spinal cord had shut down completely.

Fortunately, this story has a happy ending. When Patson woke up from surgery, he felt sensation in his legs. When he left the hospital four days later, the full strength of his legs had returned. Physical therapy helped him walk again. “Commonwealth’s integrated approach enabled me to recover completely,” says the Zimbabwe native. “Now my pain is gone and I can do anything I want. I walk two miles a day. I can sleep. I have my quality of life back.”

With Dr. Mazahery’s blessing, Patson will realize a dream later this spring when he moves to North Carolina to become a NASCAR mechanic. “This was a very unique case with many red flags, and this guy should have had a good neurological exam somewhere along the way to rule out the worst,” Dr. Mazahery says. “Happily, we had a great outcome. We hoped for the best and we got it.”

Ronald C. Childs, MD, a Major in the United States Army Medical Corp, Dr. Childs earned a BA in Psychobiology from Boston University before going on to complete his medical degree and orthopaedic surgery residency at Howard University. Dr. Childs then pursued additional training in Chicago where he completed a spine surgery fellowship program at Rush-Presbyterian—St. Luke’s Medical Center.

Steven S. Hughes, MD, graduated summa cum laude from the University of Rochester and completed his medical degree with honors from the University of Rochester School of Medicine. Dr. Hughes worked as a surgical intern at Bethesda Naval Hospital and was later honorably discharged after serving as a Commander in the United States Navy. Following his internship, he completed an orthopaedic surgery residency at Strong Memorial Hospital in Rochester and a fellowship in spinal surgery at Case Western Reserve Hospital.

Thomas Mazahery, MD, received a BA in Biology from the University of Virginia and earned his medical degree from the Medical College of Virginia. He then completed a general surgery internship and an orthopaedic surgery residency at Northwestern University. Additionally, Dr. Mazahery completed a spine fellowship at Case Western Reserve University.

Tushar Ch. Patel, MD, received his medical degree from the University of Pennsylvania and completed his internship and residency in orthopaedics at George Washington University Medical Center followed by a spine fellowship at the Cleveland Clinic Foundation. Before joining Commonwealth Orthopaedics in 2000, Dr. Patel served as Chief of the Section of Spine Surgery and as Assistant Professor in the Department of Orthopaedics at Yale University. For full biographies and a complete directory of the physicians at Commonwealth Orthopaedics who perform these and other procedures visit our website at www.c-o-r.com.
# Commonwealth Orthopaedics Office & Contact Information

<table>
<thead>
<tr>
<th>Location</th>
<th>Office Phone</th>
<th>Fax Phone</th>
<th>Address</th>
<th>Manager</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
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</table>

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- Amanda B. Truckess, MD RE/TC

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- Mark P. Madden, MD RE
- B. Thomas Mazahery, MD RE
- D. Andrew Parker, MD RE

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- Amanda B. Truckess, MD RE/TC

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- Daniel E. Thompson, MD AL/SF
- Charles R. Ubelhart, MD AL/SF
- Gordon L. Avery, MD AR/TC
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- Alexander S. Croog, MD FX/FO
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- Young J. You, MD AL/SF
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- John P. McConnell, MD AR/TC
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- Mark P. Madden, MD RE
- D. Andrew Parker, MD RE

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### Spine Non-Surgical
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### Physiatry
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- Alexander S. Croog, MD FX/FO
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- Thomas J. Klein, MD RE
- Mark P. Madden, MD RE
- D. Andrew Parker, MD RE

### Office Location Key:
- AL - Alexandria
- AF - Alexandria-Ford Ave.
- AR - Arlington
- BU - Burke
- FX - Fairfax
- FO - Fair Oaks
- HE - Herndon
- LA - Lansdowne
- RE - Reston
- SF - Springfield
- TC - Tysons Corner
- FX OPS - Fairfax Outpatient Surgery Center
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Dr. William A. Hazel, Jr. Appointed Virginia’s Secretary of Health and Human Resources

For 22 years, William Hazel, Jr., MD, has provided outstanding orthopaedic care to his patients, while helping to build Commonwealth Orthopaedics for 15 of those years into a full-service, nationally recognized musculoskeletal delivery system. Now, he has turned his attention to serving the people of Virginia as Secretary of Health and Human Resources. Governor Bob McDonnell appointed him to the four-year position in January.

In his new role, Dr. Hazel oversees 13 agencies, including the Virginia Department of Health, the Department of Medical Assistance Services (Medicaid), the Department of Social Services, and the Department of Health Professions, which licenses healthcare providers. He administers an $11 billion annual budget and directs 17,500 employees.

“I serve at the pleasure of Governor McDonnell, so first and foremost I am focused on helping him achieve his stated goals of effective and efficient government,” Dr. Hazel says. “These are challenging times in Virginia. The demand for healthcare and social services is going up, while revenues are declining. We have significant economic issues to address.”

Once the budget is established, Dr. Hazel will concentrate his efforts on improving healthcare delivery in the state. “Much of the current debate over healthcare reform misses the point,” he says. “We must look at how we take care of patients. Are we in fact offering a system that is accessible and affordable, and of high quality and safety? If not, then how do we fix it? What barriers must be removed to promote better healthcare? It is a daunting task, but the advantage of doing it at the state level is it’s a smaller lab in which to make changes.”

A respected leader locally and nationally, Dr. Hazel was a member of the American Medical Association’s (AMA) Board of Trustees and has served as speaker and president of The Medical Society of Virginia (MSV), president of the Fairfax County Medical Society, and chairman of the Inova Health System Medical Affairs Council.

As one of the founding members of Commonwealth Orthopaedics, Dr. Hazel and eight other physicians opened the first two offices back in 1994. Since then, Commonwealth has grown to become Northern Virginia’s
premier orthopaedics and rehabilitation provider, with 11 offices, 38 physicians, six physical therapy facilities, and two outpatient surgery centers.

As the first physician to hold the position of Secretary of Health and Human Resources, Dr. Hazel brings a unique perspective to the job. “I know what it’s like to care for patients in the current system and I understand the relationship between healthcare and social services,” he says. “Governor McDonnell is interested in business and innovation, so my experience building Commonwealth and my exposure to policy issues with the AMA and MSV are valuable assets in this role.”

Dr. Hazel looks forward to the future, but leaves Commonwealth Orthopaedics with reluctance and knows the next four years will be challenging ones. “I will miss my patients, my colleagues, and the Commonwealth staff, and I’ll need everyone’s support as we face the difficult choices ahead” he says. “But this is a rare opportunity and a special honor to have this position at this time.”

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Fair Oaks Office
Now Open

Commonwealth Orthopaedics opened its newest office early this year on the campus of Inova Fair Oaks Hospital.

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Fairfax, VA
703-810-5223

For more information about the new office and the eight physicians practicing there, visit www.c-o-r.com/fairoaks.
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